

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0033589</u></p> <p>Facility Name: <u>KENWOOD HEALTHCARE CENTER, INC.</u></p> <p>Address: <u>6125 Kenwood Avenue</u> <u>Chicago</u> <u>60637</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 752-6000</u> Fax # <u>(773) 752-4857</u></p> <p>IDPA ID Number: <u>36-3559960-001</u></p> <p>Date of Initial License for Current Owners: <u>04/01/86</u></p> <p>Type of Ownership:</p> <table> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve N. Lavenda</u> Telephone Number: <u>(847) 236-1111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said content: are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td>(Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Noshir Daruwalla, C.P.A.</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>FROST, RUTTENBERG & ROTHBLATT, P.C.</u> <u>111 Pfingsten Rd. , Suite 300, Deerfield, IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> <tr> <td colspan="2"> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u>	(Date) _____		(Print Name and Title) <u>Noshir Daruwalla, C.P.A.</u>		(Firm Name & Address) <u>FROST, RUTTENBERG & ROTHBLATT, P.C.</u> <u>111 Pfingsten Rd. , Suite 300, Deerfield, IL 60015</u>		(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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Facility Name & ID Number KENWOOD HEALTHCARE CENTER, INC.# 0033589 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>128</u>	Skilled (SNF)	<u>128</u>	<u>46,848</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>190</u>	Intermediate (ICF)	<u>190</u>	<u>69,540</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>318</u>	TOTALS	<u>318</u>	<u>116,388</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>8,202</u>	<u>1,775</u>	<u>1,481</u>	<u>11,458</u>	8
9	SNF/PED					9
10	ICF	<u>82,230</u>	<u>1,025</u>	<u>54</u>	<u>83,309</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>90,432</u>	<u>2,800</u>	<u>1,535</u>	<u>94,767</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 81.42%D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 04/01/88J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 04/01/88 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified _____ and days of care provided 1,387Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC** # **0033589** Report Period Beginning: **01/01/00** Ending: **12/31/00**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
1	A. General Services											1
	Dietary	338,532	23,823	4,526	366,881		366,881		366,881			
2	Food Purchase		381,274		381,274		381,274	(5,918)	375,356			2
3	Housekeeping	343,974	148,542		492,516		492,516		492,516			3
4	Laundry	131,377	30,877		162,254		162,254		162,254			4
5	Heat and Other Utilities			172,784	172,784		172,784	4,144	176,928			5
6	Maintenance	64,712		227,884	292,596		292,596	2,769	295,365			6
7	Other (specify):*											7
8	TOTAL General Services	878,595	584,516	405,194	1,868,305		1,868,305	995	1,869,300			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,936,228	28,347	3,848	1,968,423		1,968,423		1,968,423			10
10a	Therapy	49,321		1,254	50,575		50,575		50,575			10a
11	Activities	93,750	3,113		96,863		96,863		96,863			11
12	Social Services	128,881			128,881		128,881		128,881			12
13	Nurse Aide Training											13
14	Program Transportation			5,500	5,500		5,500		5,500			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,208,180	31,460	28,602	2,268,242		2,268,242		2,268,242			16
	C. General Administration											
17	Administrative	82,621		479,500	562,121		562,121	66,468	628,589			17
18	Directors Fees											18
19	Professional Services			280,835	280,835	(321)	280,514	(209,318)	71,196			19
20	Dues, Fees, Subscriptions & Promotions			33,474	33,474		33,474	2,504	35,978			20
21	Clerical & General Office Expenses	764,153	48,871	79,280	892,304		892,304	118,196	1,010,500			21
22	Employee Benefits & Payroll Taxes			489,664	489,664		489,664		489,664			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,995	2,995		2,995	652	3,647			24
25	Other Admin. Staff Transportation			1,906	1,906		1,906	6,609	8,515			25
26	Insurance-Prop.Liab.Malpractice			159,301	159,301		159,301	90	159,391			26
27	Other (specify):*							39,731	39,731			27
28	TOTAL General Administration	846,774	48,871	1,526,955	2,422,600	(321)	2,422,279	24,932	2,447,211			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,933,549	664,847	1,960,751	6,559,147	(321)	6,558,826	25,927	6,584,753			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

KENWOOD HEALTHCARE CENTER, INC.

0033589

COST REPORT RECLASSIFICATIONS

01/01/00

12/31/00

SCHEDULE V
LINE #

22 EMPLOYEE BENEFITS

2 FOOD

To reclass cost of employee meals from raw food to employee benefits

33 REAL ESTATE TAX

321

19 PROFESSIONAL FEES

321

To reclass cost of appealing real estate taxes

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			145,945	145,945		145,945	146,607	292,552			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,993	3,993		3,993	127,776	131,769			32
33	Real Estate Taxes			380,861	380,861	321	381,182	8,593	389,775			33
34	Rent-Facility & Grounds			960,459	960,459		960,459	(960,459)				34
35	Rent-Equipment & Vehicles			14,126	14,126		14,126		14,126			35
36	Other (specify):*											36
37	TOTAL Ownership			1,505,384	1,505,384	321	1,505,705	(677,483)	828,222			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		40,140	140,834	180,974		180,974	(2,096)	178,878			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			174,582	174,582		174,582		174,582			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		40,140	315,416	355,556		355,556	(2,096)	353,460			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,933,549	704,987	3,781,551	8,420,087		8,420,087	(653,652)	7,766,435			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(138,910)	30		9
10	Interest and Other Investment Income	(214,607)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(112)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,176)	21		18
19	Entertainment				19
20	Contributions	(6,697)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(169)	21		24
25	Fund Raising, Advertising and Promotional	(635)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(39,033)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (405,339)		\$	30

OHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(248,313)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (248,313)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (653,652)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID# 0033589
Report Period Beginning: 01/01/00
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch, V Line Reference
1	Deferred Maintenance	\$	6
2	Trust Fees	(100)	20
3	State Replacement Tax	(32,115)	21
4	Political Contributions - JCLTC	(499)	20
5	Legal Fees - Out of Period	(2,569)	19
6	Legal Retainer Fees	(3,750)	19
7			7
8			8
9			9
10			10
11			11
12			12
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88			88
89			89
90	Total	(39,033)	90

Summary A

12/31/00

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	Rental Income	\$ 960,459	KTNC Associates		\$	(960,459)	1
2	V	20	Amortization		KTNC Associates		9,781	9,781	2
3	V	30	Depreciation		KTNC Associates		276,080	276,080	3
4	V	32	Interest Expense		KTNC Associates		334,451	334,451	4
5	V	20	Trust Fee		KTNC Associates		300	300	5
6	V	17	Management Fees		KTNC Associates		42,188	42,188	6
7	V	19	Professional Fees		KTNC Associates		2,835	2,835	7
8	V	21	State Replacement Tax		KTNC Associates		6,089	6,089	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 960,459			\$ 671,724	\$ * (288,735)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	S.W. MANAGEMENT	100.00%	\$ 4,144	\$ 4,144
16	V	6 REPAIRS AND MAINT.		S.W. MANAGEMENT	100.00%	2,769	2,769
17	V	19 PROFESSIONAL FEES		S.W. MANAGEMENT	100.00%	10,166	10,166
18	V	20 FEES, SUBSCRIPTIONS, DUES		S.W. MANAGEMENT	100.00%	354	354
19	V	21 CLERICAL AND GENERAL		S.W. MANAGEMENT	100.00%	149,567	149,567
20	V	24 EDUCATION AND SEMINARS		S.W. MANAGEMENT	100.00%	652	652
21	V	25 TRANSPORTATION		S.W. MANAGEMENT	100.00%	6,609	6,609
22	V	26 INSURANCE - PROPERTY		S.W. MANAGEMENT	100.00%	90	90
23	V	27 PAYROLL TAXES		S.W. MANAGEMENT	100.00%	26,401	26,401
24	V	30 DEPRECIATION		S.W. MANAGEMENT	100.00%	9,437	9,437
25	V	32 INTEREST EXPENSE		S.W. MANAGEMENT	100.00%	7,932	7,932
26	V	33 REAL ESTATE TAXES		S.W. MANAGEMENT	100.00%	8,593	8,593
27	V						
28	V						
29	V						
30	V	17 SALARY - SHELDON WOLFE		S.W. MANAGEMENT		263,780	263,780
31	V	17 SALARY - RONNIE KLEIN		S.W. MANAGEMENT		30,000	30,000
32	V	27 EMP. BEN.-SHELDON WOLFE		S.W. MANAGEMENT		7,707	7,707
33	V	27 EMP. BEN.-RONNIE KLEIN		S.W. MANAGEMENT		5,623	5,623
34	V						
35	V	19 HOME OFFICE/MGMT. FEES	216,000	S.W. MANAGEMENT			(216,000)
36	V	17 MANAGEMENT FEE	269,500	S.W. MANAGEMENT			(269,500)
37	V						
38	V						
39	Total		\$ 485,500			\$ 533,824	\$ * 48,324

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	10 Pharmacy - Medicare A	29,660	Pharm-Cor	100.00%	29,660	\$	15
16	V	10 Pharmacy - Veterans	1,055	Pharm-Cor	100.00%	1,055		16
17	V	10 Pharmacy - Non-Billable	3,762	Pharm-Cor	100.00%	3,762		17
18	V	10 Pharmacy - Consultant	3,847	Pharm-Cor	100.00%	3,847		18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 38,324			\$ 38,324	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	39 Medicare A Supplement	10,480	S & E Medical Supply	100.00%	8,384	\$	(2,096)
16	V	2 Dietary Supplement	58,058	S & E Medical Supply	100.00%	52,252		(5,806)
17	V							
18	V							
19	V							
20	V							
21	V							
22	V							
23	V							
24	V							
25	V							
26	V							
27	V							
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$ 68,538			\$ 60,636	\$ *	(7,902)

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number KENWOOD HEALTHCARE CENTER, IN # 0033589 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	29.87%	See Attached	25	41.67%	Sal-SW Mgmt	\$ 263,780	17-7	1
2	Ronnie Klein	Shareholder	Administrative	6.92%	See Attached	30	50.00%	Sal-SW Mgmt	30,000	17-7	2
3	Ronnie Klein	Shareholder	Administrative	6.92%	See Attached	30	50.00%	Mgmt. Fees	210,000	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 503,780		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number KENWOOD HEALTHCARE CENTER, INC.# 0033589

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.W. MANAGEMENT
 Street Address 7434 N. SKOKIE BLVD.
 City / State / Zip Code SKOKIE, IL. 60077
 Phone Number (847) 982-2300
 Fax Number (847) 982-2304

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	H. O. / MGMT. FEE INC.	1,673,600	10	\$ 14,270	\$	486,000	\$ 4,144	1
2	6	REPAIRS AND MAINT.	H. O. / MGMT. FEE INC.	1,673,600	10	9,537		486,000	2,769	2
3	19	PROFESSIONAL FEES	H. O. / MGMT. FEE INC.	1,673,600	10	35,007		486,000	10,166	3
4	20	FEES, SUBSCRIPTIONS, DUES	H. O. / MGMT. FEE INC.	1,673,600	10	1,218		486,000	354	4
5	21	CLERICAL AND GENERAL	H. O. / MGMT. FEE INC.	1,673,600	10	515,053	446,676	486,000	149,567	5
6	24	EDUCATION AND SEMINARS	H. O. / MGMT. FEE INC.	1,673,600	10	2,244		486,000	652	6
7	25	TRANSPORTATION	H. O. / MGMT. FEE INC.	1,673,600	10	22,760		486,000	6,609	7
8	26	INSURANCE - PROPERTY	H. O. / MGMT. FEE INC.	1,673,600	10	309		486,000	90	8
9	27	PAYROLL TAXES	H. O. / MGMT. FEE INC.	1,673,600	10	90,916		486,000	26,401	9
10	30	DEPRECIATION	H. O. / MGMT. FEE INC.	1,673,600	10	32,499		486,000	9,437	10
11	32	INTEREST EXPENSE	H. O. / MGMT. FEE INC.	1,673,600	10	27,315		486,000	7,932	11
12	33	REAL ESTATE TAXES	H. O. / MGMT. FEE INC.	1,673,600	10	29,591		486,000	8,593	12
13										13
14										14
15										15
16	17	SALARY - SHELDON WOLFE	AVG. HOURS WORKED	60	10	633,071	633,071	25	263,780	16
17	17	SALARY - RONNIE KLEIN	AVG. HOURS WORKED	60	7	60,000	60,000	30	30,000	17
18	27	EMP. BEN.-SHELDON WOLFE	AVG. HOURS WORKED	60	10	18,497		25	7,707	18
19	27	EMP. BEN.-RONNIE KLEIN	AVG. HOURS WORKED	60	7	11,246		30	5,623	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,503,533	\$ 1,139,747		\$ 533,824	25

Facility Name & ID Number KENWOOD HEALTHCARE CENTER, INC.# 0033589

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Pharm-CorStreet Address 3116 S. Oak ParkCity / State / Zip Code Berwyn, IL 60402Phone Number (708) 795-7701Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Pharmacy - Medicare A	Direct Cost		\$	\$		\$ 29,660	1
2	10	Pharmacy - Veterans	Direct Cost					1,055	2
3	10	Pharmacy - Non-Billable	Direct Cost					3,762	3
4	10	Pharmacy - Consultant	Direct Cost					3,847	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 38,324	25

Facility Name & ID Number KENWOOD HEALTHCARE CENTER, INC.# 0033589

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

S&E Medical Supply

Street Address

3100 Commercial Avenue

City / State / Zip Code

Northbrook, IL 60062

Phone Number

(847) 982-9300

Fax Number

(847) 982-2304

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Medicare A Supplements	Direct Allocation		\$	\$		\$ 8,384	1
2	1	Dietary Supplements	Direct Allocation					52,252	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 60,636	25

Facility Name & ID Number KENWOOD HEALTHCARE CENTER, INC.# 0033589

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number KENWOOD HEALTHCARE CENTER, INC.# 0033589

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number KENWOOD HEALTHCARE CENTER, INC.# 0033589

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number KENWOOD HEALTHCARE CENTER, INC.# 0033589

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number KENWOOD HEALTHCARE CENTER, INC.# 0033589

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number KENWOOD HEALTHCARE CENTER, INC.# 0033589

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC** # **0033589** Report Period Beginning: **01/01/00** Ending: **12/31/00**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	KTNC Associates	X		Mortgage		06/01/81	\$ 3,900,800		12/01/07	8.00%	\$ 185,696	1	
2	KTNC Associates	X		Mortgage		01/01/86	1,654,784		06/01/04	10.00%	56,475	2	
3	KTNC Assoc.-LaSalle Bank	X		Mortgage	\$49,744.15	09/23/99	4,000,000	3,704,628	09/01/08	8.57%	92,280	3	
4	Due to Affiliated Entity	X						200,000			3,993	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$49,744.15		\$ 9,555,584	\$ 3,904,628			\$ 338,444	9	
	B. Non-Facility Related*												
10	Supplemental Schedule											10	
11	Interest Income										(214,607)	11	
12	Allocation-SW Management										7,932	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (206,675)	14	
15	TOTALS (line 9+line14)						\$ 9,555,584	\$ 3,904,628			\$ 131,769	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6	7	8	9	10
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO				Original	Balance			
1							\$	\$			\$
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											
21							\$	\$			\$

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	405,483	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	392,176	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(13,307)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	402,762	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	321	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ <u>962</u> For 19 <u>94</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	0	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	389,776	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	439,352	8
	1996	393,260	9
	1997	387,490	10
	1998	386,174	11
	1999	383,583	12

Line 2 includes SW Management real estate tax allocation of \$8593.

2000 real estate tax accrual = \$383,583 * 1.05% = \$402,762

***This bill was never used to set a rate.**

FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$
14	PLUS APPEAL COST FROM LINE 5	\$
15	LESS REFUND FROM LINE 6	\$
16	AMOUNT TO USE FOR RATE CALCULATION	\$

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number KENWOOD HEALTHCARE CENTER, INC.

0033589

Report Period Beginning:

01/01/00

Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories 6

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1991	\$ 70,754	1
2			1997	\$ 265,000	2
3	TOTALS			\$ 335,754	3

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1986		\$ 5,300,000	\$ 275,600	35	\$ 151,429	\$ (124,171)	\$ 2,271,434	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1987		643		20	32	32	467	9
10	Various		1989		5,500		20	275	275	3,231	10
11	Various		1990		62,719	693	20	3,137	2,444	45,855	11
12	Various		1991		18,602	591	20	930	339	8,981	12
13	Various		1992		80,208	2,546	20	3,913	1,367	32,934	13
14	Various		1993		325,411	8,211	20	16,663	8,452	121,597	14
15	Various		1994		35,487	882	20	2,904	2,022	18,257	15
16	Various		1995		66,379	1,692	20	3,319	1,627	19,216	16
17	HI-GRADE PAINT		1996		7,219		20	361	361	1,685	17
18	TILE		1996		15,715	403	20	786	383	3,865	18
19	TILES		1996		2,477	64	20	124	60	620	19
20	BACAK TANK SYSTEM		1996		4,800	553	20	240	(313)	1,020	20
21	GCS-BOILER & WATER C		1996		3,995	357	20	200	(157)	833	21
22	ACUATOR		1996		1,563	180	20	78	(102)	338	22
23	PLUMBING		1996		573		20	29	29	145	23
24											24
25	PAGE 12-I REP TOTALS				169,097	5,229		5,515	286	29,799	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	PAGE 12B TOTALS				117,344	30,630		4,914	(25,716)	4,914	34
35	PAGE 12A TOTALS				387,422	42,975		19,950	(23,025)	65,020	35
36	TOTAL (lines 4 thru 35)				\$ 6,605,154	\$ 370,606		\$ 214,799	\$ (155,807)	\$ 2,630,211	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ELEVATOR		1996		4,857		20	243	243	1,134	9
10	ACUATOR		1996		5,930		20	297	297	1,485	10
11	PARKING LOT		1996		1,990	139	20	100	(39)	467	11
12	BOILER		1996		9,375	240	20	469	229	2,228	12
13	PARKING LOT		1996		9,050	634	20	453	(181)	2,114	13
14	GAS VALVE		1996		4,462	514	20	223	(291)	1,041	14
15	DRAIN LINES		1996		780		20	39	39	195	15
16	PARK - LANDSCAPING		1997		159,067	12,240	20	7,953	(4,287)	30,487	16
17	BATHROOM		1997		25,520	654	20	1,276	622	4,785	17
18	BATHROOM		1997		15,660	402	20	783	381	3,067	18
19	BLINDS		1998		5,596	1,074	20	280	(794)	1,260	19
20	ELEVATOR-PUMP UNIT		1998		24,800	636	20	1,240	604	2,893	20
21	PAINTING & DECORATING		1998		9,556		20	478	478	956	21
22	WEATHER TEMP DAMPERS		1998		23,385	4,091	20	1,169	(2,922)	5,262	22
23	20 AMP CIRCUITS		1998		2,131		20	107	107	427	23
24	HEATING COIL		1999		6,671	2,135	20	334	(1,801)	945	24
25	200 AMP BREAKER		1999		2,565	821	20	128	(693)	385	25
26	CARPET		1999		3,285	1,051	20	164	(887)	411	26
27	AIR CONDITIONER		1999		10,544	3,374	20	527	(2,847)	878	27
28	225 AMP POLE BREAKER		1999		1,962	628	20	98	(530)	294	28
29	CARPET		1999		1,600	512	20	80	(432)	147	29
30	CHILLED WATER COIL		1999		7,515	2,405	20	376	(2,029)	627	30
31	CONCRETE COATING		1999		5,050	129	20	253	124	337	31
32	MASONRY		1999		15,135	388	20	757	369	1,072	32
33	RADIATOR		2000		5,900	5,900	20	246	(5,654)	246	33
34	WALLPAPER		2000		21,712	4,343	20	1,628	(2,715)	1,628	34
35	WALLPAPER		2000		3,324	665	20	249	(416)	249	35
36	TOTAL (lines 4 thru 35)				\$ 387,422	\$ 42,975		\$ 19,950	\$ (23,025)	\$ 65,020	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALLPAPER			2000	1,470	294	20	110	(184)	110	9
10	WALLPAPER			2000	1,196	239	20	90	(149)	90	10
11	WALLPAPER			2000	883	177	20	66	(111)	66	11
12	MINI BLINDS			2000	65	13	20	5	(8)	5	12
13	BOILERS			2000	4,514	3,944	20	188	(3,756)	188	13
14	WALLPAPER			2000	3,115	623	20	130	(493)	130	14
15	DISHWASHER EXHAUST			2000	5,907	5,907	20	296	(5,611)	296	15
16	WINDOW TREATMENT			2000	1,020	204	20	34	(170)	34	16
17	WALLPAPER			2000	4,663	933	20	350	(583)	350	17
18	WALLPAPER			2000	1,099	220	20	73	(147)	73	18
19	WALLPAPER			2000	3,146	629	20	210	(419)	210	19
20	WALLPAPER			2000	826	165	20	55	(110)	55	20
21	WINDOW TREATMENT			2000	18,430	3,686	20	768	(2,918)	768	21
22	WALLPAPER INSTALL			2000	63,355	12,671	20	2,112	(10,559)	2,112	22
23	WALL GAURD			2000	1,498	21	20	44	23	44	23
24	ELEVATOR REPAIR			2000	1,800	33	20	68	35	68	24
25	WALLPAPER			2000	825	165	20	62	(103)	62	25
26	WALLPAPERS			2000	2,081	416	20	156	(260)	156	26
27	WALLPAPER			2000	1,451	290	20	97	(193)	97	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 117,344	\$ 30,630		\$ 4,914	\$ (25,716)	\$ 4,914	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
21												
22												
23												
24												
25												
26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
21												
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24												
25												
26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
21												
22												
23												
24												
25												
26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
21												
22												
23												
24												
25												
26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1995	Alloc. SW	\$ 130,687	\$ 3,351	35	\$ 3,737	\$ 386	\$ 17,381	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various - KTNC Associates			1983	799		20			799	9
10	Various - KTNC Associates			1986	8,225	433	20	428	(5)	6,198	10
11	Various - KTNC Associates			1987	1,493	47	20	47		681	11
12	Allocation - SW Management			1995	13,410	692	20	801	109	3,547	12
13	Allocation - SW Management			1996	2,342	60	20	117	57	418	13
14	Allocation - SW Management			1997	3,372	421	20	242	(179)	545	14
15	Allocation - SW Management			1998	2,322	60	20	116	56	203	15
16	Allocation - SW Management			1999	6,447	165	20	27	(138)	27	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 169,097	\$ 5,229		\$ 5,515	\$ 286	\$ 29,799	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
21												
22												
23												
24												
25												
26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.** # **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 811,998	\$ 40,120	\$ 68,785	\$ 28,665		\$ 471,719	37
38	Current Year Purchases	45,216	15,873	2,104	(13,769)		2,104	38
39	Fully Depreciated Assets	665,164	2,663	5,717	3,054		665,164	39
40								40
41	TOTALS	\$ 1,522,378	\$ 58,656	\$ 76,606	\$ 17,950		\$ 1,138,987	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility	Ford 1998	1998	\$ 18,966	\$ 2,950	\$ 1,897	\$ (1,053)	5	\$ 4,426	42
43										43
44										44
45										45
46	TOTALS			\$ 18,966	\$ 2,950	\$ 1,897	\$ (1,053)		\$ 4,426	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 8,482,252	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 432,212	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 292,552	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (138,910)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 3,773,624	51

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

KENWOOD HEALTHCARE CENTER, INC.
0033589
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Kenwood Healthcare Center	666,656	39,623	66,353	26,730	396,982
KTNC Associates					
SW Management	25,484	497	2,432	1,935	13,885
KTNC Associates Partnership II	119,858				60,852
TOTALS	811,998	40,120	68,785	28,665	471,719

LINE 29: CURRENT YEAR

Kenwood Healthcare Center	41,025	11,682	2,042	(9,640)	2,042
KTNC Associates					
SW Management	4,191	4,191	62	(4,129)	62
KTNC Associates Partnership II					
TOTALS	45,216	15,873	2,104	(13,769)	2,104

LINE 30: FULLY DEPRECIATED

Kenwood Healthcare Center	188,164	2,663	5,717	3,054	188,164
KTNC Associates	477,000				477,000
SW Management					
KTNC Associates Partnership II					
TOTALS	665,164	2,663	5,717	3,054	665,164

TOTALS (Should Tie to Totals on Page 13)

Kenwood Healthcare Center	895,845	53,968	74,112	20,144	587,188
KTNC Associates	477,000				477,000
SW Management	29,675	4,688	2,494	(2,194)	13,947
KTNC Associates Partnership II	119,858				60,852
TOTALS	1,522,378	58,656	76,606	17,950	1,138,987

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00Ending: **12/31/00****XII. RENTAL COSTS****A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease: **N/A**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.9. Option to Buy: ☒ YES ☐ NO Terms: _____***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☒ YES ☐ NO16. Rental Amount for movable equipment: \$ **25**Description: **\$25 Walkers/Wheelchairs**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	1998 Jaguar XJ8	\$ 1,135	\$ 14,101	17
18					18
19					19
20					20
21	TOTAL		\$ #####	\$ 14,101	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2001 \$ _____

13. _____/2002 \$ _____

14. _____/2003 \$ _____

* If there is an option to buy the building,
please provide complete details on attached
schedule.** This amount plus any amortization of lease
expense must agree with page 4, line 34.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**
 XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

0033589 Report Period Beginning: **01/01/00** Ending: **12/31/00**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 63,786	\$		\$ 63,786	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			14,945			14,945	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			58,671			58,671	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				29,660		29,660	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	**SEE SUPPLEMENTAL Other (specify): SCHEDULE**					3,431	10,480		13,911	13
14	TOTAL			\$		\$ 140,833	\$ 40,140	\$	180,973	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 Medical Supplies	
2 Complex Medical Equip	
3 Oxygen	
4 Equipment Rental	
5 Enteral Feeding	10,480
6	
7	
8	
9	
10	
	<u>10,480</u>
<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1 Respiratory Therapy	
2 Lab	3,431
3	
4	
5	
6	
7	
8	
9	
10	
	<u>3,431</u>

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 1,338,280	\$ 1,453,242	1
2 Cash-Patient Deposits	29,522	29,522	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,978,037	1,978,037	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	65,164	65,164	6
7 Other Prepaid Expenses	1,666	1,666	7
8 Accounts Receivable (owners or related parties)		78,000	8
9 Other(specify): See supplemental schedule	1,938,631	1,938,631	9
TOTAL Current Assets			
10 (sum of lines 1 thru 9)	\$ 5,351,300	\$ 5,544,262	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	70,784	335,784	13
14 Buildings, at Historical Cost		5,300,000	14
15 Leasehold Improvements, at Historical Cos	779,203	789,720	15
16 Equipment, at Historical Cost	1,211,066	1,804,764	16
17 Accumulated Depreciation (book methods)	(1,148,346)	(5,940,551)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs		(12,227)	20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):		88,031	22
23 Other(specify): See supplemental schedule			23
TOTAL Long-Term Assets			
24 (sum of lines 11 thru 23)	\$ 912,707	\$ 2,365,521	24
TOTAL ASSETS			
25 (sum of lines 10 and 24)	\$ 6,264,007	\$ 7,909,783	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 116,045	\$ 118,545	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	130,743	130,743	28
29 Short-Term Notes Payable	200,000	200,000	29
30 Accrued Salaries Payable	167,646	167,646	30
31 Accrued Taxes Payable (excluding real estate taxes)	18,607	18,607	31
32 Accrued Real Estate Taxes(Sch.IX-B)	402,762	402,762	32
33 Accrued Interest Payable		27,339	33
34 Deferred Compensation			34
35 Federal and State Income Taxes		1,362	35
Other Current Liabilities(specify):			
36 See supplemental schedule		141,208	36
37			37
TOTAL Current Liabilities			
38 (sum of lines 26 thru 37)	\$ 1,035,803	\$ 1,208,212	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable		3,704,628	40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43 See supplemental schedule			43
44			44
TOTAL Long-Term Liabilities			
45 (sum of lines 39 thru 44)	\$	\$ 3,704,628	45
TOTAL LIABILITIES			
46 (sum of lines 38 and 45)	\$ 1,035,803	\$ 4,912,840	46
47 TOTAL EQUITY (page 18, line 24)	\$ 5,228,204	\$ #REF!	47
TOTAL LIABILITIES AND EQUITY			
48 (sum of lines 46 and 47)	\$ 6,264,007	\$ #REF!	48

*(See instructions.)

STATE OF ILLINOIS

Page 17 SUPP-1

Facility Name & ID Number KENWOOD HEALTHCARE CENTER, INC.

0033589

Report Period Beginning: 01/01/00

Ending:

12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES

As of 12/31/00

OTHER CURRENT ASSETS:

	Amount	Amount
Real Estate Tax Escrow	88,242	88,242
Employee Loans	5,850	5,850
Short Term Loan Exchange	1,844,539	1,844,539

<u>1,938,631</u>	<u>1,938,631</u>
------------------	------------------

OTHER NON CURRENT ASSETS:

Construction In Progress
Utility Deposit
Loan Costs

<u> </u>	<u> </u>
<u> </u>	<u> </u>

OTHER CURRENT LIABILITIES:

	Amount	Amount
Accrued Expenses		
Accrued R. E. Tax - Non Care Property		
Due to KTNC, Inc.		49,965
Due to JLR		3,000
Real Estate Tax Escrow		88,243

<u> </u>	<u>141,208</u>
-----------------------------	----------------

OTHER NON CURRENT LIABILITIES:

<u> </u>	<u> </u>
<u> </u>	<u> </u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,911,750	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,911,750	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,906,454	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,590,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 316,454	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,228,204	24

* This must agree with page 17, line 47.

Facility Name & ID Number	KENWOOD HEALTHCARE CENTER#	0033589	Report Period Beginning:	01/01/00	Ending:	12/31/00
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Balance per General Ledger	4,911,750
----------------------------	-----------

Adjustments:

-
-
-

Total adjustments

-

Balance - Beginning of Year

4,911,750

Equity(Deficit) from Page 17 Col 1

5,228,204

Related Party

Equity(Deficit)

Income

-2231261

0

(2,231,261)

Combined Equity - End of Year

2,996,943

Facility Name & ID Number KENWOOD HEALTHCARE CENTER, INC.

0033589

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,809,669	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,809,669	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	179,591	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 179,591	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	120,061	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 120,061	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	214,608	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 214,608	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	2,612	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,612	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,326,541	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,868,305	31
32	Health Care	2,268,242	32
33	General Administration	2,422,600	33
	B. Capital Expense		
34	Ownership	1,505,384	34
	C. Ancillary Expense		
35	Special Cost Centers	180,974	35
36	Provider Participation Fee	174,582	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,420,087	40
41	Income before Income Taxes (line 30 minus line 40)**	1,906,454	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,906,454	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? [Not Available](#) If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

DESCRIPTION	AMOUNT
1 Vending Commissions	1,650
2 Real Estate Tax Refund	962
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	<u>2,612</u>

Facility Name & ID Number KENWOOD HEALTHCARE CENTER, INC.

0033589

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 55,057	\$ 26.47	1
2	Assistant Director of Nursing	440	469	14,169	30.21	2
3	Registered Nurses	10,413	11,216	213,542	19.04	3
4	Licensed Practical Nurses	45,371	46,821	868,412	18.55	4
5	Nurse Aides & Orderlies	85,167	91,951	785,048	8.54	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,978	6,784	49,321	7.27	8
9	Activity Director					9
10	Activity Assistants	10,287	11,160	93,750	8.40	10
11	Social Service Workers	13,265	13,938	128,881	9.25	11
12	Dietician					12
13	Food Service Supervisor	7,769	8,150	102,587	12.59	13
14	Head Cook	3,168	3,258	25,245	7.75	14
15	Cook Helpers/Assistants	30,587	32,824	210,700	6.42	15
16	Dishwashers					16
17	Maintenance Workers	5,446	6,020	64,712	10.75	17
18	Housekeepers	50,329	52,587	343,974	6.54	18
19	Laundry	15,267	17,296	131,377	7.60	19
20	Administrator	2,000	2,080	82,621	39.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	48,477	52,417	764,153	14.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	336,964	359,051	\$ 3,933,549 *	\$ 10.96	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 4,526	1-3	35
36	Medical Director	Monthly	18,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,847	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	21	1,254	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	21	\$ 27,627		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		\$	\$
0	0	\$ 0	\$ #DIV/0!

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Ruth Gebert	Administrator	N/A	\$ 82,621
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 82,621
B. Administrative - Other			
Description			Amount
Ronnie Klein-Management Fee			\$ 210,000
SW Management-Management Fee			269,500
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 479,500
C. Professional Services			
Vendor/Payee	Type		Amount
Frost, Ruttenberg & Rothblatt	Accounting		\$ 21,508
Personnel Planners	Unemployment Consultant		3,375
Ashman & Stein	Legal		33,588
Fleis Court Reporting	Legal		591
Winston & Strawn	Legal		1,541
Lefkovitz & Associates	Legal		321
Stone, Pogrud, Korey	Legal		3,911
S.W. Management	Home Office		216,000
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 280,835
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 65,717
Unemployment Compensation Insurance			51,103
FICA Taxes			300,515
Employee Health Insurance			31,652
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Chicago Head Tax			1,432
Life Insurance			4,800
Other Employee Benefits			34,445
TOTAL (agree to Schedule V, line 22, col.8)			\$ 489,664
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 35
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed 96)			1,156
Licenses/Fees			18,247
Classified Advertising			4,797
Dues & Subscriptions			56
Inspections			1,252
Advertising & Promotion			635
Allocation - SW Management/KTNC			10,435
Less: Public Relations Expense			()
Non-allowable advertising			(635)
Yellow page advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 35,978
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			2,995
Allocation - SW Management			652
Entertainment Expense			()
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 3,647

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER, INC.**# **0033589**Report Period Beginning: **01/01/00**Ending: **12/31/00****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on Long Term Care \$13,598
- (3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES _____ NO X
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over KTNC Associates
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 174,582
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ _____ Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% In 1
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "All Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/rw